PRESCRIPTION FORM FOR ADMINISTRATION OF MEDICATION IN SCHOOL

To be completed by physician for all medication administered <u>including over the counter medications</u>

Student's Name: _____ D.O.B.: _____ Grade: _____

Diagnosis:_____

Name of Medication: _____ Dosage: _____

Time and Circumstances of Administration: _____

Possible Side Effects: _____

Length of time the prescription is valid (Must be reviewed annually): _____

When specific guidelines are followed, a student may self-administer medication. Self-administration of a prescribed medication is permitted only in exceptional circumstances when a life-threatening condition exists. For purposes of the Board policy a life-threatening illness is defined as "...an illness or condition that requires an immediate response to specific symptoms or sequelae that if left untreated may lead to potential loss of life such as, but not limited to, the use of an inhaler to treat asthmatic attack or the use of an adrenaline injection to treat a potential anaphylactic reaction."

When self-administration of medication is applicable for a life-threatening condition and in accordance with West Windsor-Plainsboro School District policy guidelines are as follows:

Grades K-3 - No student will be allowed to self-administer medication without the assistance of a nurse.
Grades 4-5 - A student will be allowed to use inhalers without nurse assistance on field trips **only**.
Grades 6-12 - A student may self-administer medication for life-threatening illnesses (**EpiPen, inhaler and/or insulin**)

_____ is capable and has been instructed in the proper method of
(Student's name)
self-administration of _____ as directed.
(permitted medication listed above)

When an auto-injector is prescribed, please provide the following information:
Is there a documented history of anaphylaxis? Yes _____ No _____
If yes, please provide the signs/symptoms of this child's anaphylactic episode(s):_____

_____

_____
Signature of Physician Date

Stamp

PARENT/GUARDIAN MUST ALSO COMPLETE THE PARENT PERMISSION FOR ADMINISTRATION OF MEDICATION FORM

WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT
Parent Permission for Administration of Medication in School

Student's Name: _____ DOB: _____ Grade: _____

Administration of medication during school hours **is not** encouraged. However, if a physician determines that failure to take medication would jeopardize the health or school attendance of a student, the medication will be given by the school nurse. In so doing, the West Windsor-Plainsboro Board of Education and its employees shall incur no liability for any benefits or consequences occurring from the administration of the medicine.

I hereby request that the school nurse administer _____ as
(name of medication)
directed by my physician. I will supply the medication in its original container and personally deliver it to the school nurse.

Medication Information /Adjustments
If this medication is to be given on a regular basis, please indicate what needs to be done if the student is on a class trip or on early closing days. ***Teaching staff cannot administer***.

Check One:

_____Student will not be taking the medication when going on a class trip.

_____Administer the medication when the student returns from the class trip.

_____Parent will administer the medication when accompanying student on the trip.

Circle One: **Administer**/**Do Not Administer** the medication on early closing days.

When applicable and in accordance with the West Windsor-Plainsboro School District's policy, I give permission for my son/daughter to self-administer the above medication. I also understand that the self administration privilege shall be revoked if it is deemed that my son/daughter has failed to comply with school policy and tenets of the agreement to self-medicate.

I relieve the West Windsor-Plainsboro Board of Education and its employees of any liability for the benefits or consequences arising from the administration or student self-administration of this medication.

_____ _____

Signature of Parent/Guardian Date

_____

Parent/Guardian Name